The Future of the Managed Care Industry and Its International Implications

David Woods
President
Healthcare Media International

Being asked to comment about the future of anything is a mixed blessing. On the one hand, for an editorialist, it offers an irresistible combination of temptation and opportunity. On the other hand, one is mindful of the many individuals who have upended themselves memorably on the banana peel of prediction.

For instance, in 1800, Thomas Malthus, a practitioner of what later became known as the dismal science of economics, famously foretold of a world population imminently to be extinguished by its inability to feed itself. Today, a senior fellow of the respected Hoover Institute of Stanford University claims that "the entire population of the world could be housed in the state of Texas in single-story, single-family homes, four people to a house, with a typical yard around each home." This assumes of course, that you could persuade them all to move to Texas. And then there was Yogi Berra's remark, "the only thing I wouldn't predict is the future."

To try to get a glimpse of the future of managed care, one has to look at its past and trace its evolution to the present day. Some have compared managed care to Wilhelm Conrad Roentgen's 1895 discovery of x-rays, because managed care looks deep into the body of traditional healthcare to discern what ails it. Cynics might forge a different metaphor, that Roentgen called his Nobel prize-winning invention "x-ray" because he wasn't quite sure how it worked or exactly what its influence might be.

The humorist Robert Benchley once observed that the human race is divided into two types of people: those who divide the world into two different types of people, and those who do not. Where managed care is concerned, it seems there *are* two different types of people – those who hate it and those who merely loathe it. But having spent seven months away from my day job studying managed care, and having also observed the British and Canadian

systems favored by some Americans, I've come to a slightly more charitable view of it.

I'd like to give you a brief overview of managed care's history and evolution, the backlash against it, its international potential and possible future, and how, perhaps chiefly out of enlightened self-interest, it has the opportunity to make preventive medicine more than merely piety and preaching.

Managed care is not a new idea or event a recent one. Its origins can be traced to the 1880s when German chancellor Otto von Bismarck developed a form of prepaid health insurance for workers as a means of staving off socialist plans for government-run insurance. He also, by the way, cannily invented the notion of retirement and pensions at the age of 65, at a time when few lived long enough to collect them.

In the U.S., HMOs, the original form of managed care, date back to 1933 when a young California surgeon, Sidney Garfield, accepted the invitation of Henry Kaiser to provide his thousands of workers with care on a prepaid basis. Garfield then renovated an aging institution in Oakland and called it the Permanente Foundation Hospital. "Permanente" is Spanish for everlasting, and it was named for the Permanente River which ran continuously even in the dry season. Thus, Kaiser Permanente was born, the prototype for the modern managed care movement.

During WWII the federal government froze all wages and salaries. Employers circumvented the restriction by offering nonmonetary perks instead. One of the most popular was health insurance. In 1973, President Richard Nixon signed a bill requiring all employers with a workforce of 25 or more to offer HMO coverage. The legislation, not unlike Bismarck's, was intended to muzzle the calls of Senator Edward Kennedy and others for a national health system. But what fueled the dramatic growth of managed care in the 1980s was the realization the traditional fee-for-service indemnity insurance model of health care delivery was impossible to sustain. Moreover, there was little evidence that these enormous medical expenditures made Americans any healthier or longer-lived than people in other developed

countries. Part of the problem was what George Bernard Shaw called, in his play of that name, the Doctor's Dilemma. That dilemma is that physicians get paid for doing, they don't get paid for not doing; therefore they did and America's rates of hysterectomy, coronary bypass, and C-section deliveries were unnecessarily high. But also, American ingenuity and technological advances made available such state-of-the-art, procedurally expensive capabilities as MRI and organ transplantation.

Back in 1965, Americans spent $46 billion a year on health care, 6% of the Gross National Product (GNP). In 1997, the total topped $1 trillion, an almost impossible amount to imagine, 14% of the GNP, or about $4,000 for every American, making U.S. healthcare the world's largest industry and eighth largest economy. Consider that when President Eisenhower suffered a heart attack in 1955, he was prescribed bed rest, oxygen, anticoagulants, and morphine. If the attack had occurred a decade or so later, he might have received a coronary bypass, a procedure whose incidence today is 350,000 a year at a cost of roughly $40,000 apiece. All of this created another dilemma, one that Dr. William Kissick, Professor of Medicine at the University of Pennsylvania and manager of that university's Wharton School, calls infinite demand versus finite resources. My medical school colleagues tell me no cost is too great to save a life or to treat a disease; my management school colleagues tell me that resources are limited and choices must be made. When, in 1994, Americans balked at President Clinton's proposals to introduce a government-run medical system, they had little option but to consider the only viable alternative, managed care. Today some 80% of Americans covered by their employers are in some form of managed care. Yearly cost increases slowed from a high of about 16% in the 1980s to a 35-year low of 4.6% in 1996, due in part to managed care's dampening some of the excesses and expectations that prevailed under the old system.

So healthcare planners faced the urgent and monumental challenge of lowering medical costs while assuring patients quality and access. These three facets—access, cost, and quality—make up what Kissick calls the Iron Triangle that he and other policy analysts generally claim constitutes an ideal healthcare model.

There are numerous definitions of managed care. Dr. Edward Hughes, a professor at Northwestern University, defines it as the application of standard business practices to the delivery of health care in the best traditions of the U.S. free-enterprise system. Professor Alain Enthoven of Stanford University, a leading authority on health care systems and policy, defines it as a strategy that purchasers of health care services use to obtain resources at value for money. Like Hughes, Enthoven believes that market forces can transform the health care delivery system from its former fragmented condition, where nobody was accountable for their actions (except in court), into efficient, integrated, comprehensive care organizations that are constantly striving to improve. But although the yearly escalation of healthcare costs has slowed dramatically since managed care took hold, critics contend that the savings made by managed care organizations are a result of taking what they call the low-hanging fruit; denying certain types of treatment, squeezing payments made to hospitals and doctors, and severely cutting back the length of hospital stays. There is considerable truth in this. A 1997 study in the *Journal of the American College of Surgeons* found that among 5,600 patients, waiting for elective surgery, were sent a second opinion, 490 procedures were found to be medically unnecessary.

Nevertheless, under managed care, physicians feel they have lost much of their autonomy and consumers grumble about lack of choice and about the allegedly unseemly rewards reaped by managed care organizations and their executives. And yet, while MCOs have cut waste, duplication, and overutilization, and have therefore been able to provide better value insurance for employers, they've seen their own operating profits decline from 8% in 1994 to an estimated 3% for 1996, with industry leader Kaiser Permanente experiencing a multimillion dollar loss for 1997; and Oxford Health Plans, once the darling of the managed care organizations, showing a half-billion dollar loss in the second quarter of 1998. So much for the river running continuously, even in the dry season.

Despite studies showing that the quality of care has not been demonstrably compromised under managed care, it's hard to find any friends of the system among either doctors or patients. Ask about alternatives, or look for positive articles about managed care and you

seek in vain. The media cite horror stories about denial of care; even TV series such as "ER" feature doctors trying to do good despite managed care's strictures. Audiences applauded loudly when Helen Hunt did a managed care rant in the movie *As Good as it Gets*. All of this despite the fact that, to paraphrase Winston Churchill on the subject of democracy, managed care is the worst form of health care except for all those other forms that have been tried from time to time.

Much of the criticism is at least in part a reaction to dramatic and rapid change. The reality is that, yes, managed care forces doctors to be more cost-conscious and team-oriented; and it makes patients more informed, discerning, and self-reliant, but what concerns many doctors is the notion that medicine is defined by what it doesn't do. Alain Enthoven says that many physicians feel that the incentives of per capita payment will motivate them to do less for the patient than might be necessary – to skimp. But, he is quick to add that when he hears doctors complain, he points to some of his good friends who are doctors and who don't make those complaints because they accepted responsibility to manage costs and quality.

Alain Enthoven goes on to say that society wants quality, managed, cost-contained care, and the logical people to organize, manage, and run it are doctors, he says, because they are the best informed and the most professionally committed. Enthoven's advice to doctors is to regain their autonomy by getting organized and taking charge, starting by refusing to deal with the current average of 15 health plans and arranging to partner with just 2 or 3.

"Doing managed care here is a complex business," says Enthoven. "In the short run, the poor performers may be confused with the good and try the patience of the public with the whole enterprise, but over time with an appropriately structured market serving informed people, the good will drive out the bad."

Will managed care, like Coca-Cola, jeans, and fast food, become a global American influence? There are several compelling reasons to believe that it will, parts of it at least. To begin with, fierce battles have erupted among MCOs over existing and future customers. And, as

domestic legislation tightens over what managed care companies may or may not do, and as profit margins shrink, many of those companies are looking to expand overseas.

And the timing is right. Globalization is the new buzzword. Trade barriers are falling; there is a worldwide shift to a service economy and there are health care varieties, such as aging populations and burgeoning technology, that transcend national boundaries. Governments are seeking ways to contain costs while maintaining or improving quality, and many look to the U.S. as a leader in exporting sales, service, and marketing efficiencies.

But, there are cultural and attitudinal barriers to wholesale adoption of the U.S. healthcare model. Other nations don't necessarily share Americans' unique optimism that leads them to believe that if only they spend enough money on healthcare, death can be postponed, possibly even avoided altogether. As one Scottish physician who moved from Scotland to Canada to California said, in Scotland death is imminent, in Canada death is inevitable, and in California death is optional.

And while managed care embraces Americans' values of quality, choice, competition, high technology, and most of all mistrust of government, these are not necessarily values shared by other nations. For instance, the state-run system in Canada, which Canadians cherish, keeps a tight rein on global budgets for doctors, hospitals, and technology. Canada has seen its doctors go on strike; waiting times for elective surgery, already lengthy, have increased by 10% - 15% in the past year. Canadians spend more than $1 billion a year buying health care in the U.S. Even so, most Canadian provinces are developing utilization review programs, outcomes measurements, and other techniques of the managed care system.

In Britain, the National Health Service (NHS) celebrates its 50th anniversary this year. When the postwar Labor government introduced the service, its proponents believed that the nation's health would steadily improve and therefore costs would decline. Today, the NHS suffers from underfunding, long waiting lists for elective procedures, a shortage of doctors, and low staff morale. Even though Britons consider healthcare to be free, but not free

enterprise, more of them, about $6 million, are opting for private healthcare. Expenditures on that are still only about 4% of the total annual health budget of $75 billion. The new White Paper in Britain on health services proposes what it calls a "third way." The first two ways involved a gargantuan bureaucracy whose total of employees was said to exceed that of the former Soviet Army or the Indian railway system; and then second some tinkering with market forces that is based upon adopting some of the management precepts of managed care.

Asia also represents fertile ground, not only for U.S. companies seeking to plant their managed care business there, but also for domestic organizations capitalizing on an explosive healthcare market that is expected to reach $360 million by the year 2000. The same holds true for Latin America. Managed care is also being studied in India, China, Thailand, and Vietnam.

What of the future? Despite having largely replaced a fee-for-service system that was characterized by overutilization, fragmentation, and astronomical costs, despite the cries of outrage from the press and politicians, and despite organized medicine's obstructions and individual physicians' objections, managed care has not only survived, it will almost certainly prevail. It will also certainly evolve. The present 1,000 or so managed care companies will, through mergers and acquisitions, dwindle to perhaps 20 or 30 by the first decade of the 21st century.

Managed care will focus on quality, choice and access, not just cost-cutting. What cost-cutting there is will come from genuine innovation, especially in information technology. Computers will enable managed care to do exactly that – manage care, not just costs. Huge databases of information on patients' and providers' use of healthcare delivery, and outcomes will help to determine optimal treatment programs.

With an aging population and increasingly sophisticated and expensive medical technology, pressure to raise prices will be severe. The Washington-based coalition on health care

released a report in mid-1997 showing that healthcare costs will rise dramatically again over the next 5 years, outpacing inflation by a 2-to-1 margin.

The reasons: consumers are price-sensitive when buying plans, and insensitive when using services, largely because when someone else is paying they perceive the service to be free. Consumer groups oppose restrictions needed to hold costs down; lawyers and politicians seek ever-tighter regulation of managed care organizations.

Dr. Peter Kongslvedt in his landmark work, *The Managed Healthcare Handbook,* notes that preventive services are a hallmark of the managed care industry. Common preventive services include immunizations, mammograms, routine physical examinations, and health assessments and counseling about behavior that the member can undertake to lower the risk of ill health. Kongslvedt reports that in one managed care study, an employer held worksite prenatal education programs and found that participants had an average cost per delivery that was $3200 less than that for nonparticipants. On substance abuse, he states that, "despite historical separation of substance abuse and mental health programs, effective systems integrate treatment programs that tailor the appropriate mix of services to each individual's treatment needs."

Professor Ray Robinson, in his review of 70 studies comparing managed care with fee-for-service, found that one of the earliest claims for MCO's was that they had an incentive to keep people well through preventive healthcare and health promotion. The research evidence offers strong support for this claim, he stated. In 32 of the 44 observations we assembled on this subject, patients in MCO's received higher levels of service than those in fee-for-service. In the remaining 12, 10 found no significant difference in prevention activities.

According to the American Association of Health Plans, 100% of MCOs cover well-baby care, immunizations, routine physicals, and mammography for women over 50, and more than 96% cover adult immunizations and influenza immunizations.

Substance abuse, despite its increasing incidence and the trend toward workplace testing, has not had the profile it merits where prevention and early intervention are concerned. Dr. Nelba Chavez's study, released November, 1997, showed that employees who receive drug and alcohol information and access to employee assistance programs from their employers are less likely to abuse drugs and alcohol. The Center for Substance Abuse Prevention awards for studying the impact of such programs across a broad spectrum are affordable and certainly merit managed care organization support.

Most employers, when they moved from fee-for-service to managed care, tend to offer managed care through one company or possibly two. Instead, employers could give the money to employees and require that it be used for healthcare insurance - thereby shifting the choice to the individual and generating what Enthoven calls managed competition. Under managed competition, people will choose the managed care organizations that best fit their needs.

In conclusion, I believe American managed care is here to stay. Although it is flawed - i.e., a work in progress - it is attracting international attention, and it has shown some real advantages in the area of prevention.

Question:

The last time I heard a talk on this topic in relation to managed care and prevention, there was a lot of talk that managed care organizations felt that the time horizon for the impact of preventive services was beyond that of when a particular person would be maintained by that company. It seems like there been a change in that thinking – why or how?

Answer:

I think this is a matter of enlightened self-interest. A managed care company confronted with a person who is obese, hypertensive, chain-smoking, doesn't exercise, and has high

cholesterol, would be well advised to deal with some of that at the outset rather than pay $40,000 for a bypass operation down the road. It makes fiscal sense. It has nothing to do with charity or philanthropy, it has to do with economic reality.

Comment:

Being in the managed care field myself, I can say that it is difficult being in an industry where everybody hates you. So I just wanted to thank you for presenting the only balanced presentation that I've heard.

Question:

It's all well and good to require physicians to do preventive healthcare, but the way physicians have been trained and the way they've been reimbursed ever since the beginning of time has been to take care of the immediate needs of the patient.

When the patients come in for a problem, you have to deal with that medical problem at that time. At the same time, managed care is pushing physicians to spend less and less time with each patient, for each encounter. So you have this real conflict of a physician who wants to know or knows about preventive care; they're not really trained to do that, but even if the doctor is motivated to do that, he/she doesn't have time within the little block they're given. They're being squeezed to see more and more patients. So I see that as a real problem. The other problem I see is that it is in the best interest of the managed care community to prevent illnesses, but they manage their budgets on a fiscal-year basis, and if their turnover rates are high, they may be putting a lot of money into preventing something that will only help the next MCO the next year to gain profits. So, how do we get around that problem?

Answer:

Well, two things address the problem. The first is that talk about physicians spending less

time. Physicians are actually spending a little bit more time with their patients on average. The other thing one hears from physicians is that their income is going down. In 1994 there was a slight dip in overall income, but now it's starting to go up again to average about $200,000.

Comment

I'm hearing from a lot of physicians I know that the managed care environment is squeezing them to see more patients in less time. So, that's how they feel. Also, there are a lot of consumers who believe they're not getting good care and the reason is because it would cost more money. I had someone come to me and say, "do I have a malpractice case because my son went in with a damaged arm and the physician ordered an X-ray of the arm, but not of the collarbone which was broken?" This gentleman thought that the reason both X-rays weren't ordered was because it was going to cost more. Which is absurd, but this is how consumers feel about managed care, and you're right, this is a huge public relations problem. I think until some of these issues are overcome, we're going to continue to have serious problems with managed care and the perception of it.

Comment

I certainly agree with the general global picture that you're presenting. This is also the first time I have heard a balanced, as opposed to a more emotional presentation.